Better Homes and Centers

Michigan Department of Social Services

Health Practices

Issue 26 Fall 1990

WASH THOSE GERMS AWAY

Rosanna Maureen Stewart
Group Day Care Home
Washtenaw County

One of my major concerns since I began caring for children has been keeping them healthy. This is important to me for two reasons. First, my own family is exposed to all illnesses in my child care home. Second, I care for the children of many young, single mothers who do not get paid for staying home with sick children.

I began by trying all the usual precautions such as encouraging hand washing; using paper towels, plates and cups; disinfecting silverware, the changing table and the toilet area; and teaching children to use tissues and to cover their mouths when coughing. These measures are important and necessary, but they were not enough.

During our first year of operation, we stayed sick from October to May. It seemed as though we would never be healthy. We caught every cold and flu bug around, not to mention measles and chicken pox. Our second year was better but we still had several episodes of flu and numerous colds. Runny noses became the standard. As the beginning of our third year approached, I began to consider this problem seriously and search for a solution.

Fortunately, I was given an opportunity to ask for help through a program called "Hooray for Health." This is a new Washtenaw County Public Health program which provides consultation services to child care providers. I explained that I wanted to develop a health program that would reduce our instances of sickness and would be feasible and easy to implement.

During our six weeks in this program, I discovered that we had a good foundation of health practices, but needed to expand our basic ideas. We were overlooking some real germ-breeding grounds such as the bathroom sink, faucet handles and door knobs, eating areas,

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DIRECTOR'S CORNER

As we begin a new school year, we look for ways to improve our program, stimulate learning in our children, and anticipate the good times to come. We generally do not think about the bad times we could have, such as severe injuries or perhaps the death of a child while in care. Tragedies can happen, and the results are traumatic not only for the parents but for you as caregiver. They don't always happen to someone else. Some of you have had to endure such things as a child who died from "Sudden Infant Death Syndrome" (SIDS). When such tragedies occur, support groups may be available to both parents and providers. Generally, either your local health department or hospital may be able to give you information regarding these groups.

New family and group home rules require that providers receive training in infant and child CPR and basic first aid. Does being "prepared" help? By all means, as indicated by the following letter from parents who were fortunate to have a provider who was prepared. The parents have given me permission to reprint their letter.

To Whom It May Concern:

We would like to take this opportunity to commend licensed day care provider Barbara Schmelter for her outstanding care for our son, Nicholas.

On June 29, 1990, Nicholas had an apnea (cessation of breathing) episode while in her care. Barbara proved her competence by administering CPR and resuscitating him, quickly calling paramedics and ultimately, saving our baby's life! Fortunately, she followed the "check every 20 minutes" rule as he had only been down 15 — 20 minutes when this episode occurred.

We are grateful to Barbara for being such a competent caregiver and wanted you to be made aware of this fact. She is and has been exemplary not only in this situation, but overall in her care of Nicholas.

We hope that you will recognize and acknowledge Barbara for her outstanding service. We will be forever indebted to her.

Sincerely,
Gary and Susan Basham

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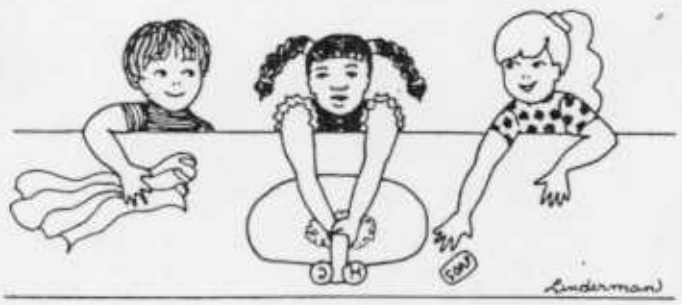
counter tops, kitchen appliances and any toys that are put into children's mouths. In addition, a surface that children touch in an effort to balance themselves should be disinfected with a bleach solution.

Developing a hand washing routine is necessary for success. Use an antibacterial bar soap as it cleans better. Demonstrate hand washing for the children so they understand that you want them to lather the soap and rub their hands all over. Use paper towels for drying — one towel per hand washing. Dispose of used towels in a wastebasket. If you follow through each time, the children will soon be telling you when to wash your hands.

Hands should be washed:

1. Before and after eating.
2. After using the bathroom.
3. After coughing or sneezing.
4. After blowing noses (your own or someone else's).
5. Before and after touching a child's mouth.
6. After changing diapers.
7. Before preparing food. (We have a strict rule against doing other things during food preparation. The adult who is cooking doesn't change diapers, tie shoes, blow noses, or find missing objects. The children know that they have to go to the other adult for help or wait until the meal is ready.)
8. After playing outside.
9. After using markers, crayons and pencils.
10. After caring for each child, before helping the next one (diapers, noses, etc.).

The changes we made and the new ideas we incorporated reduced our illnesses significantly. We have had no flu epidemics and only a few mild colds since we implemented the program last fall. With the help of the "Hooray for Health" consultant and consistent application of health care procedures, we feel that we have a workable, practical, and useful tool for ensuring a healthier child care environment.



DIRECTOR'S CORNER . . .

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Mrs. Basham also wished to pass on some additional information she thought would be of interest to others caring for young children. She wanted me to encourage providers to ask parents if the baby in care was premature or was ever on an apnea monitor. These babies should be watched particularly closely, since they are more likely to experience problems with cessation or suspension of breathing.

We all share in this family's heartfelt gratitude for the response their son received from this provider. Tragedies can sometimes be prevented. One child makes it all worthwhile.

Ted deWolf, Director
Division of Child Day Care Licensing

Please send articles for consideration in future issues to:

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CHILDHOOD DISEASES ARE NOT KID STUFF

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Infectious diseases have been a major concern when attempting to provide assurance of quality in child care. The usual focus has been on the health and well-being of children rather than the health of staff members. Children, however, are a reservoir for many infectious agents, and because caregiving staff come into close and frequent contact with children and their excretions and secretions, child care workers are at major risk of developing a variety of infectious diseases.

Caregiving staff are predominantly women, most often of child-bearing age. Certain infections contracted by a pregnant woman may also endanger the developing fetus. All child care workers need to be informed of the risks of working with young children. Maintenance of age-appropriate routine immunizations for all children and caregiving staff is the hallmark of primary prevention of infectious disease in child care facilities.

Caregiving staff should be up-to-date for all vaccines recommended for adults. This includes a primary series for tetanus and diphtheria, and a booster vaccination against these agents every ten years. Recommendations also include being immune to measles, mumps, poliomyelitis, and rubella viruses.

While virtually all persons born before 1957 are immune to measles, 10-15 percent of individuals born since 1963 may not be immune, and therefore would be susceptible to infection. Rubella virus may have devastating effects upon the developing fetus and approximately 10 percent of young adults are not immune to this virus today. Determination of presence of antibodies to measles, mumps, and rubella is one means of assuring protection against these infectious agents. In areas where these tests are not readily available, however, immunization (or re-immunization) with measles, mumps, rubella vaccine (MMR) may be more practical, and should be considered for healthy caregiving staff.

Three other diseases for which vaccines do not yet exist or are not appropriate for adults deserve mention. Tuberculosis, a serious bacterial infection, is on the increase nationwide. Testing for prior exposure and infection with ***Mycobacterium tuberculosis*** is accomplished by use of a tuberculin skin test. Such skin testing should be performed prior to starting employment and at regular intervals as recommended by local health authorities.

Varicella zoster virus (chickenpox) infection occurring in adults may result in a serious illness, especially in those with underlying chronic health problems. Approximately 8 percent of American adults (over 15 years of age) are not immune to chickenpox. While a positive history of disease is a reliable indicator of immunity, blood testing should be considered for those caregiving staff with unknown or negative histories of disease. Should an outbreak of chickenpox occur at a child care facility, susceptible staff may wish to remain at home for the duration of the outbreak to decrease their risk of exposure.

Finally, all caregiving staff should receive education concerning the increased probability of exposure to cytomegalovirus (CMV) in child care settings. While healthy children are usually not adversely affected by this infection, they may transmit it to parents and/or adult caregivers.

CMV is the leading cause of congenital infection in the United States; and a primary infection in a pregnant woman carries the greatest risk of damaging after effects. Transmission of CMV appears to require direct contact with virus containing body fluids (saliva and urine), thus careful attention to hygiene (hand washing and avoidance of secretions) is vitally important to preventing infection in caregiving staff. In large studies involving over 30 centers and 500 adult staff each, researchers in Alabama and Virginia found antibody evidence of recent infection of 14-20 percent. A blood test to determine a worker's immunity to CMV is available and has been recommended by some specialists.

Children and caregiving staff in child care settings probably are at a higher risk of exposure to certain diseases than is the general population. Many of these diseases, however, can be successfully prevented by effective measures such as immunizations, improving hygiene standards, and better disease recognition and control.

CHILDREN WITH CHRONIC ILLNESSES IN THE CHILD CARE SETTING

Barbara Desguin, M.D.
The Department of Pediatrics and Human Development
Michigan State University

When a child in a child care setting has a chronic illness, particular issues need to be considered and some adaptations may be required. Ten to twenty percent of all children have chronic illnesses. Of the total group of children with chronic illnesses, 10 percent are profoundly affected while the other 90 percent function generally as healthy children do. In Michigan approximately 300,000 children between birth and 18 years have chronic illnesses, and it is likely that many of them are in child care settings at some point in their childhood.

What are Chronic Illnesses?

Childhood chronic illness has been defined medically as a condition which "requires care for three month in a year, or hospitalization more than one month a year, or at the time of diagnosis is likely to do so." Another definition is "A continuing disorder which results from an impairment of a body system or structure, has a course which is measured in months or years, is characterized by the need for continuing or periodic medical treatment or health care, and has the potential to interfere with a variety of functions on a continuing basis." It is clear from the general nature of these definitions, that a wide variety of conditions are "chronic illnesses." Asthma, allergies, and seizures are examples of chronic illnesses which are relatively common in childhood. Ear infections may be chronic in younger children. Less common illnesses include diabetes, cystic fibrosis, leukemia, cerebral palsy, arthritis, and heart and kidney disease. Chronic illnesses may range from mild to severe, and their severity may change over time.

Which Children can be Enrolled?

Since the majority of children with chronic illnesses are able, in general, to function normally, they can be in usual child care settings. Decisions about enrollment should be based on the needs of the particular child and the ability of the facility to meet them. Each center or home must consider whether it is able and willing to care for the child. Some illnesses require special considerations. If older children who need total assistance with daily care are enrolled, an adequate number of staff must be provided. Children who are dependent on technical equipment such as trachcostomics, tube feedings, or ventilators need staff who are trained to provide such care and observe for problems. In general, children with such needs may not be able to be cared for in child care centers, however, they may be cared for in homes in which the caregivers have received specific training. Children who have diseases of the immune system are not able to resist infections normally and such children may be put at risk by the usual infections of other children in the home or center.

What Needs to Be Done?

For the home or center caring for the child with a chronic illness there are four areas to be considered: ***obtain complete information, provide an appropriate setting, give needed care,*** and ***keep the illness in perspective.*** To provide appropriate care, the following information should be obtained from the parent and, if necessary, the child's physician:

- What is the child's illness?
- What is the child's usual level of function? (What can he do or not do?)
- What care is needed?
  If medications: how much, when, how is it measured and given, and are there any possible expected or unexpected effects?
  If diet: what foods are required or prohibited, on what schedule?
- What adaptations need to be made? (e.g.: storage of medications, a quiet place for the child to lie down)
- What problems, if any, may occur (including emergencies)?
- What symptoms should be watched for?
- When should someone be contacted?
- Whom should be contacted? Who is the child's physician? (obtain all telephone numbers which might be needed)

While few adaptations will be needed for the majority of children with chronic illnesses, the provision of an appropriate setting means that facilities or programs may have to be adapted according to the answers to the above questions. Such adaptations may involve staff, the physical environment, or the child's program and activities.

The provision of appropriate care means that the home or center should:

- Create and maintain schedules for medications or treatment.
- Make information such as telephone numbers easily accessible.
- Give all staff clear and complete information about what is to be done and what problems could be encountered.
- Maintain daily appropriate records of medications or treatment.

If the child seems to be ill, the staff should observe and record information about items such as activity, behavior, appetite, and unusual signs such as fever, vomiting, diarrhea, wheezing, or seizures. If the child becomes ill, specific information about how much or how long is very useful to the parent and physician. For example, "he vomited four times since noon", is more helpful than "he's been vomiting some today." Since these children have the usual acute illnesses experienced by healthy children, it is important **not** to assume that all signs of illness are due to the child's chronic illness.

While these considerations may seem overwhelming, it is important to keep the child's illness in perspective. Most children with chronic illnesses will function like their healthy peers most of the time and will require only limited care and observation. The child's activities should not be restricted ***just because*** he or she has a chronic illness. The attention of the child or the other children present should not be drawn to the illness or any limitations the child may have. It is important to view the child with a chronic illness as a child who needs the same care, attention and opportunities as all other children. A sound base of information, careful procedures for giving care and keeping records, and a focus on the child, rather than the illness, should provide the best experience for the child and the center.

1. Hobbs, N., et al. *"Chronically Ill Children in America"*, Rehabilitations Literature, Vol. 45, #7-8, July-August, 1984.

2. Desguin, B., et al. *"School Children with Chronic Illness: A Longitudinal Study of Kindergarten Pupils"* Final Report to the Michigan Board of Education, 1989.

Dr. Desguin is the director of the Comprehensive Care Clinic for Children with Special Health Care Needs.

LYME DISEASE UPDATE

FACTS TO REMEMBER:

LYME DISEASE:
- Is most prevalent in the Upper Peninsula; however there have been cases reported in the Lower Peninsula.
- Causes chronic arthritic-like pain.
- Is spread by the deer tick. Favorite hosts include mice, birds, dogs, opposums, deer, horses, racoons, and humans.
- Most prevalent months are May to September.

SYMPTOMS:
- Initial symptoms (within one month): flu-like, with headache, muscle and joint pain, nausea, chills and fever. A bulls-eye shaped rash may be found on one or more areas of the body a few weeks later. Possible conjunctivitis (pink eye).
- *Several weeks to several months after the bite:* heart palpitations, headaches, irritability, sleeplessness, poor coordination, fatigue, numbness, tingling and facial paralysis.
- *Months or years later:* Arthritis and in some cases, heart trouble.

OUTDOOR PROTECTION:
- *When entering a brushy, wooded area,* especially in the Upper Peninsula, wear long-sleeved, light-colored clothing. Tuck pant legs into boots. Spray tick repellent such as Permamore (designed to be sprayed on clothing only) or any product with 30 percent DEET (check labels) on clothing near wrists, ankles, and neck. Avoid walking in tall grass.

BACK HOME:
- Check skin at hairline, nape of neck, back of ears, armpits, and waistline. (Deer ticks are about the size of the period at the end of this sentence). Take a shower — they usually don't bite for a couple of hours. If you find one, grab it with tweezers at the point of the bite, then gently but firmly tug it off. Disinfect with alcohol, and save the tick for inspection by putting it in a jar with a cotton-ball moistened with water. Keep cats and dogs off furniture, particularly the beds. Tick collars may help, but don't count on them.

For more information, contact the Michigan Lyme Borreliosis Support Group, c/o Jane Huegel, 231 Lockwood Street, Saginaw, MI 48602. Phone (517) 792-7170.

AIDS, A FOUR LETTER WORD?

Sue Bruno, Administrator
Steps Montessori School
Saginaw, Michigan

"There is only one way to deal with an individual who is sick: with dignity, compassion, care, confidentiality and without discrimination." President Bush.

People who are HIV infected are now living longer, thereby increasing the chances that they will give birth to HIV-infected children. Treatment for HIV-infected children continues to improve, lengthening their life spans. These two factors will result in a growth in the number of HIV-infected, preschool-age children. Having a communicable disease policy in place provides clearly defined steps of action which should meet the needs of the school without compromising the rights, needs, and dignity of an infected student or staff member.

Our board's objectives were:

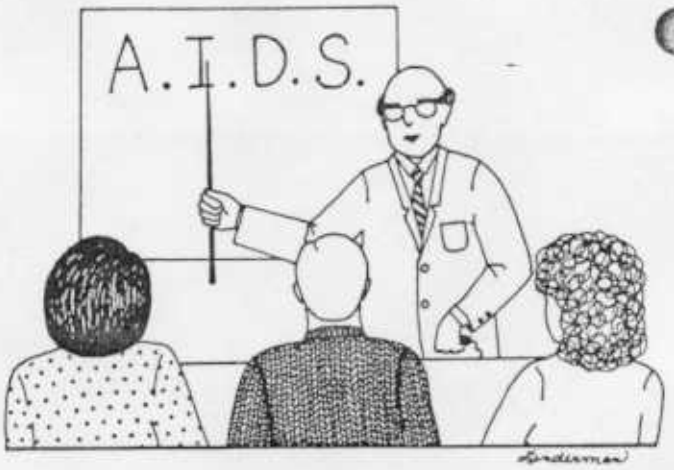
a. To be able to talk about AIDS without stomachs tightening.
b. To open the door to parent communication regarding the issues surrounding communicable diseases.
c. To identify valuable resources in our Public Health Department, Department of Social Services, Department of Education and local school district office.

Fear was the initial emotion that had to be dealt with as our parent board, representing 60 families, began to look at developing a communicable disease policy. Emotions ran high as we explored fact and fiction in the issues surrounding those diseases "not spread by casual contact."

About halfway through this six-month process, Mary Cornford, health education coordinator with the Saginaw Intermediate School District, met with our board. She provided accurate information regarding methods of transmission, allowed a question-and-answer opportunity and provided us with direction and continuous consultation. In addition, our education director, Linda Gilson, met with a committee from the board to pull out pieces from the many available models and to shape a policy for our school.

Because more information about communicable diseases becomes available every day, we wanted our policy to be very general and allow us to make decisions based on the most up-to-date information.

Our approach was to establish a review panel tailored to the needs of our school. Members could be



the school administrator, board member(s), an area health official, a child advocate, the child's parent and the child or staff member's physician. This panel could be called together within 72 hours of receiving reliable evidence confirming the infection of a student or staff member. All persons involved in these procedures are required to treat all proceedings and documents as confidential information. Access to this information was limited to *only those persons who need to know*.

Included in the policy are items the panel is to use in its review:

1. The circumstances in which the disease is contagious to others.
2. Any infections or illnesses the student/staff member could have as a result of the disease that would be contagious through casual contact in the school situation.
3. The age, behavior, and neurological development of the student.
4. The expected type of interaction with others in the school setting and the implications to the health and safety of those involved.
5. The psychological aspects (for both the infected individual and others) of the infected individual remaining in the school setting.
6. Consideration of the existence of contagious diseases occurring within the school population while the infected person is in attendance.
7. Consideration of a potential request by the person with the disease to be excused from attendance in school or on the job.
8. The method of protecting the student/staff member's right to privacy, including maintaining confidential records, and who in the school setting "needs to know" the identity of the affected individual.

RESOURCES – HEALTH

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"*Care of Ill Children in Child Care Programs.*" Child Care Information Exchange. July, 1987.

"*Exclusion Criteria for Ill Children in Child Care.*" Child Care Information Exchange. May, 1986.

"*Lice— No Cause for Hysteria.*" Child Care Information Exchange. November, 1986.

"*Why is Adult Health An Issue in Day Care?*" Child Care Information Exchange. March, 1984.

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Goodman, R., Osterholm, M., Grandoff, D., and Pickering, L. "*Infectious Diseases and Child Day Care.*" Pediatrics. 74 (1) 1984.

Green, Martin I. *A Sigh of Relief: The First-aid Handbook for Childhood Emergencies.* Bantam Books. 1984.

Kendrick, Amy Shapiro, Kaufmann, R. and Messenger, K., Editors. *Healthy Young Children: A Manual for Programs.* National Association for the Education of Young Children. 1988.

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National Safety Council. "*Ten Facts About Colds.*" Volunteers' Voice for Community Safety and Health. November/December 1985.

"*Don't Get Burned From a Microwave Oven.*" January/February 1988.

Pantell, Robert H., M.D. Fry, J. M.D. and Vickery, D. M.D., *Taking Care of Your Child: A Parents Guide to Medical Care.* Addison-Wesley Publication Co. 1977.

AIDS . . .

(Continued from page 6)

9. Recommendations as to whether the student/staff member should continue in the school setting or, if currently not attending, under what circumstances he/she may return.
10. Recommendations as to whether a restrictive setting or alternative delivery of school programs is advisable.
11. Determination of whether an employee would be at risk of infection through casual contact when delivering an alternative education program.
12. Determination of when the case should be reviewed again by the panel.
13. Any other relevant information.

When the policy was completed, we sent a copy to our parents and encouraged their feedback. The feedback was positive and provided further opportunity for open communication about a previously "touchy issue." The policy received unanimous board approval.

The entire process was not unlike the one we follow in helping young children overcome their fears. Identify, discuss, educate, support, and allow time to grow. We are still growing.

DON'T EAT YOUR FRUITS AND VEGETABLES WITH DETERGENT

You'll be replacing one inedible residue with another if you try to sanitize fresh fruits and vegetables by rinsing them in a soap or detergent solution. "Soap and detergent were never meant for human consumption," says Carolyn Moody, an Extension Foods and Nutrition Specialist with the University of Missouri—Columbia. "The best way to rid fresh food of any pesticide residue is to rinse it thoroughly with plain water." Rinsing with plain water has been a long-standing recommendation for food safety, she says. "I don't care how diluted the solution is, it's next to impossible to rinse away soap or detergent from the porous texture of fresh fruits and vegetables," Moody says. "Ingesting soap or detergent could lead to diarrhea or mild stomach upsets."

Reprinted from *Little Folks*, Eaton Cooperative Extension Service, sponsored by the Eaton County Child Abuse and Neglect Prevention Council, August 1989.

PROVIDER'S CORNER

Many of us have one in our homes and centers. It is convenient and it is fast. It's called a microwave. We use it to heat up a variety of food items. But did you know that heating up bottles of milk or furmula or baby food can be dangerous?

According to the National Safety Council, "Heating a bottle of formula or milk in a microwave oven presents a potentially serious scald hazard.

Most of these injuries involve bottles with disposable plastic liners. The liquid is heated and the baby (and sometimes the adult) sustains a scald burn when the liner ruptures and the hot liquid comes in contact with his or her skin. The heated liquid, while in the microwave, does not burst the liner, but when the bottle is removed and rotated (turned over) or shaken, the pressure increases and the liner ruptures."

Formula or milk in glass bottles and baby food cooked in the microwave may be unevenly cooked, causing hot spots.

It is probably wise to use the old fashioned way of heating bottles and baby food. However, if the microwave is still your first choice, follow the safety tips suggested by the Shriners Hospitals for Crippled children, Burns Institute, Cincinnati Unit:

- "Read and follow the directions for appliance use and operation.
- Determine the safe time and energy cycle for heating specific foods.
- After an item has been heated, let it set for a short period before handling the food or attempting to remove the covering (or attempting to serve the item).
- Remember that some foods may heat unevenly — especially frozen items. One area may be very hot and another very cold. Stir food, especially portions near the edge of a container, and use caution when eating.
- Keep all hot liquids out of the reach of children."

National Safety Council. (see Resource section)

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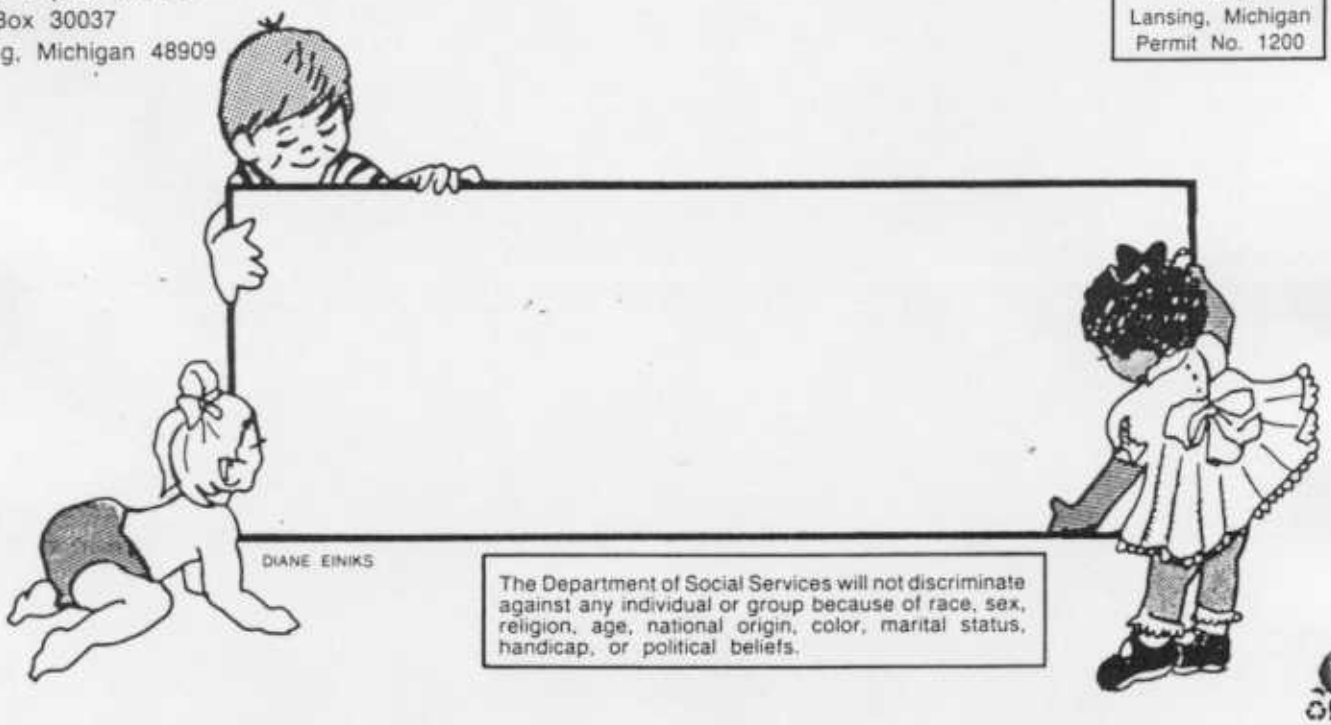

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